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TO: Each Supervisor

FROM: Thomas L. Garthwaite, MD
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SUBJECT: **QUALITY IMPROVEMENT STRATEGIC PLAN FOR LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES**

Purpose

The purpose of this memorandum is to inform your Board of the Department's Plan of Action and Timeline to enhance our quality improvement processes.

Background

Over the past several years, several reports on the quality and consistency of the American healthcare system have been published. The most widely read reports were published by the Institute of Medicine. Their first report "To Err is Human: Building a Safer Health System" received wide attention primarily via the headline that up to 98,000 Americans die each year as the result of preventable errors in the health system. Their second report, equally or more troubling than the one on errors, received less public coverage. It was entitled "Crossing the Quality Chasm: A New Health System for the 21st Century." Its disturbing message is that the difference between what we know that works in health care and what we routinely deliver is not a small valley, it is a chasm.

The Healthcare Industry is among the most watched and scrutinized systems anywhere. In addition to the rich array of regulatory and accrediting bodies that routinely assess our work as they would any healthcare system [Appendix A], DHS facilities undergo additional oversight from educational accreditations and the press which is aided by the Public Records Act. The inconsistent and often poor state of healthcare in America that is described above exists despite current efforts at oversight and many efforts to improve it. Since the Institute of Medicine reports were released there has been considerable work in many healthcare institutions to improve. Nationally, organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have placed increasing emphasis on patient safety and reduction of

medical errors. In 2004, JCAHO promulgated a group of patient safety goals with which each accredited organization must show evidence of compliance. Other organizations, such as the National Patient Safety Foundation and the National Quality Forum have been focusing on ways to address the problem of medical errors. Implementation of computerized systems, vigilance in identifying these events and addressing them systemically will help to reduce the incidence of medical errors much like the airline industry has reduced the frequency of catastrophic airplane accidents. Addressing medical errors systemically is critical.

The Department is focusing on several areas to improve patient safety and eliminate or reduce the likelihood of injury from medical errors. There is a patient safety committee that has established organization-wide policy related to JCAHO's patient safety goals. As part of the Department's performance monitoring activities, staff from the Quality Improvement Program are collecting data in several areas and reporting these to the Department's Health Leadership Board. The data results drive improvements in processes and policies to effect positive results. QIP has also published and distributed to all DHS clinical employees, a patient safety handbook that focuses on identifying and reporting errors.

However, DHS facilities, like their private sector counterparts, remain far from perfect: despite our new performance measurement system, despite the extensive external oversight, despite the accreditation inspections and reviews, despite the week-long top to bottom inspections, despite the good intentions of many great front line employees and their managers, and despite an entirely new leadership team. However, all these actions and a focus on correcting all identified weaknesses and deficiencies have helped. The Department is making progress as evidenced by objective performance data, by the comments of outside oversight agencies and by the feedback from front line employees. We have not and cannot rely on adverse events and outside inspections to discover any additional defects. The Department believes that we must solidify and expand our current efforts at quality improvement. We must improve the system by which we identify weaknesses in other systems.

Action Plan

A. CULTURE OF QUALITY

The Department is dedicated to continuous improvement. For that goal to become a reality, each employee must internalize the meaning to them. Quality must be expected by each employee from themselves and from their co-workers. Changing that culture will require consistent action over a long period of time.

As a start, we will:

a. Engage clinicians and administrators from across the system to perform "tracer" audits (the new, positively received method of quality review being used by JCAHO), either at their own or another DHS facility.

b. Invest in the education of key clinical leaders in modern quality improvement methods with the objective of implementing what they have learned upon their return from the educational experience.

As a result of these efforts, the Department will expect to see more cross-fertilization among facilities, creating a healthy competition and a positive change in the quality culture. The focused sharing of education will also create a core group of inter-facility experts who can be deployed to various facilities for consultation and assistance in addressing specific quality issues.

B. CREDENTIALING AND PRIVILEGING PROCESS

Credentialing is a core process that must be completed for all clinical staff prior to working in a health care facility. The process documents that training claimed by the provider took place and that licenses are current and active. Credentialing provides the organization with a baseline by which to assess educational competence and requires knowledgeable professional to interpret. For example, certification in surgery from 20 years ago would not imply competence in a new procedure such as laparoscopic surgery (which is less than 20 years old). A provider claiming credentials for this procedure would need to establish additional training and/or certification before competence would be assumed.

Privileging refers to the process of granting permission by the facility to an individual practitioner to perform specific medical practices. Using the same example, the privilege to perform laparoscopic surgery would have to be requested by the surgeon before it was automatically granted. Privileges may be granted on the basis of evidence (training or successful performance of procedure in another hospital) but may also require direct observation of the practitioner by another physician (proctoring). The credentialing and privileging process must be rigorous to ensure that the right practitioners are providing competent care. Re-privileging requires evidence of current competence.

We will:

a. Review our current processes to ensure that data supports the level of privileges requested, including data on procedure specific outcomes, as applicable.

b. Review our current proctoring practice. Is it timely and consistent across services within each facility? Are there biases within services that prevent this from being a fair process?

c. Review the medical leadership within each facility to assess their competence in providing the appropriate level of oversight in the credentialing and privileging process. How are they assured that the process, is it working, what criteria are used?

d. Ensure comparable credentialing/privileging process in all DHS facilities.

As a result of these activities, I will better understand how each facility is currently credentialing and privileging providers. I will be able to assess the medical leadership in their oversight of these processes and I will be able to intervene or direct the medical leadership to intervene if there are practitioners with inappropriate or inconsistent privileges. A solid credentialing process will ensure that only providers who have been assessed as competent care for patients.

C. PEER REVIEW PRACTICE

Among the hardest assessment in understanding and improving quality is to determine the judgment of the individual practitioner. In most cases of patient injury, there is a system failure. In some cases, there is poor judgment by the practitioner. A key question is "Is this lapse in judgment the result of a good practitioner making a rare bad decision or is this practitioner's judgment frequently outside that of his/her peers?" Peer review attempts to answer that question.

We will:

a. Review how are cases chosen for routine peer review? Is there a systematic process in place to look at certain numbers of cases, certain types of cases?

b. Review processes for random blind reviews of interpretations such as x-ray/imaging studies and pathology?

c. Establish a process of random review of charts on a regular basis? Set standards for number and quality of peer review.

d. Emphasize the need to identify instances of judgment or technical errors that are not associated with bad outcomes.

e. Establish department wide peer review standards determine the level and nature of peer review. Should it be "Department-wide" or "facility-wide"? What is the best practice nationally to overcome the reticence of practitioners to be constructively critical of other practitioners?

Strengthening the peer review process will encourage the critical evaluation of care that is necessary to learn from errors and close calls. A robust peer review system should be able to identify borderline practitioners and intervene before they cause a critical patient event. Peer review practices are steeped in medical tradition. They need to become more systematic.

D. FACILITY LEADERSHIP

Quality improvement requires leadership and commitment from the top.

We will establish a Departmental assessment and ongoing review of the leadership for quality improvement in each cluster along the following parameters:

a. What is the participation of leadership in performance improvement?

b. Does each facility have an effective way to evaluate the quality of care in their facility How do they prioritize QI projects?

c. How successful are they at "closing the loop" on quality issues?

d. What data is there to support the loop being closed?

e. Do committee minutes reflect analysis of performance improvement data and action plans?

f. Is there follow through on action plans?

g. Is this information routinely shared with staff and with the Governing Body?

h. Assess service chiefs' mechanisms and abilities to assess competence and manage quality in their departments.

i. Review Medical Directors' role and mechanisms to assess Service Chiefs' performance in assuring quality in their services.

As a result of this emphasis on facility leadership, I hope to establish a level of accountability for quality in each facility that goes beyond the regulatory requirements. Our leaders must be fully engaged in identifying and resolving quality issues under their control and must not hesitate to advance quality issues outside of their facility if they cannot be solved locally.

E. ROOT CAUSE ANALYSES

The traditional approach in health care to solve quality problems has been to hold individuals accountable for their individual actions. The new, and more rational, approach is to hold systems accountable for understanding the root causes of the problems and for instituting system-wide processes to prevent the problem or to minimize any consequences.

a. Train a core team of leaders and internal trainers to teach true root cause analysis across DHS.

b. Develop a system of sharing the events to solicit other thoughts and ideas for improvement and share the findings to rapidly spread the improvements system-wide.

c. Develop a series of incentives and rewards for identification of root causes that lead to demonstrated fixes.

Fixing the root cause of a medical error presumes that the error will not recur. As a result of these efforts, the Department should see a reduction in repetitive errors. Also, by systematically sharing information across the system, the Department should be able to intercept errors before they occur at another facility.

F. CRITICAL EVENTS

Critical events are usually patient injuries or deaths that occur in a healthcare setting that are unexpected. They may or may not be preventable. Close calls are dangerous situations that did not lead to an injury or death due to staff intervention or due to luck.

a. Continue to operate a critical event reporting system.

b. Institute daily rounds and reports from nursing and resident physicians to identify events as they happen to assure that all events are reported.

Numerous studies have shown that not all errors are reported. To address medical errors, we must know about them and work to resolve their root causes. Instituting a daily rounds process at each facility will put leaders at the bedside, soliciting information. The openness in reporting will allow more root causes to be identified and thus more opportunity to fix malfunctioning systems.

G. MISCELLANEOUS INITIATIVES

a. Move to the review of open and active charts of current inpatients (rather than the charts in the medical records department) to assure that appropriate documentation is contemporaneous.

b. Conduct on-site unscheduled reviews of supervision in the OR.

c. Build off the ICU best practices group's early successes and feed their reports through the DHS Quality Improvement Committee to the Health Leadership Board.

d. Establish an Emergency Department Best Practices Group and assess other clinical areas that could benefit from a similar process. Our experience from the ICU group is that their discussion is patient and medical literature focused and that the discussion and data gathering that they do leads to a sense of team and to a healthy competition among facilities.

e. Reality checks: Establish a monthly visit of key Departmental staff (Director, COO, Director of Quality and Performance) to selected nursing units to have an in depth discussion regarding communication, teamwork, concerns, thoughts and suggestions.

Increased visibility of Department leaders will encourage the kind of open communication that enhances the quality culture. Expanding current quality initiatives to other areas allows the entire Department to benefit from the work of a few.

Resources

The Department is not requesting additional resources for this initiative. We will reprioritize our time and educational funding to support this effort. Many hours are currently being spent on Quality Improvement activities. We will focus that time and demand more return on the time currently invested.

Estimated Timeline

Weeks	Action
1	First meeting with service chiefs and medical directors set the stage, ask for data
1	Organize ED Best practices, charge this group and ICU group with data collection
2-3	Analysis of data, first tracer at a facility, first visit to a nursing unit.
3-4	Analysis of data, second tracer at a facility
4-8	Service by Service meetings to review credentialing/privileging/peer review
9	Second meeting with service chiefs and medical directors, provide status report, get feedback
10-14	Facility leadership meetings to evaluate participation in QI, third tracer, second visit to nursing units.
15	Review of RCA from each facility, fourth tracer
16-17	Operating room visit to assess supervision
17	Third meeting with service chiefs and medical directors, provide status report, get feedback
18	ED visit to assess supervision, fifth tracer
19-21	Third visit to nursing units for discussion of quality

22	Fourth meeting service chiefs, medical directors, CEO's, provide status report, get feedback
22-24	Prepare final report

At the conclusion of this intensive quality review, the following objectives will have been met:

- A core group of leaders will develop expertise in quality improvement methods
- The medical leadership's ability to oversee credentialing and privileging will be assessed
- Specific aspects of the peer review system will be strengthened
- Facility leadership will be more engaged in the quality of care at their facility
- Root cause analyses will be strengthened, a reduction of repetitive medical errors should result
- An increase in reported events will occur, with more identification of root causes and demonstrable system fixes.
- More best practices groups will be convened to share information and recommend Department policy
- Department leadership will become more visible in the organization, leading to more openness and enhancing the quality culture.

It is premature to speculate on the types of actions that will be taken as a result of this information. However, I plan to use the information gained from this intensive review to influence the allocation of Departmental resources and to aid in the identification of poor performers. Much of this information will be valuable as the Department designs its incentive system and the pay for performance system for physicians.

TLG:ol

Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

Appendix A

Listing of Regulatory Agencies that assess the Healthcare Industry:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- State Department of Health Services (SDHS)
- Centers for Medicaid and Medicare Services (CMS)
- Occupational Safety and Health Administration (OSHA)
- College of American Pathologists (CAP)
- Department of Managed Care (DMC)
- National Committee on Quality Care (NCQA)
- Office of Statewide Health and Planning Department (OSHPD)